OUTPATIENT HOSPITAL FEE SCHEDULE PROJECT
SUMMARY OF CHANGES
2/2/2005 TO 6/6/2005

Customer Change Requests - Approved:

01 Multiple Peer Groups for a Facility

Need to allow for services to fall under distinct Peer Group percentages, as necessary. Added values PG1 through PG9, which will be found on PR050.

Example – ABC Hospital

PGM @ 100% for all HCPCS/CPT codes except 99283-99285.

Has PG1 @ 150% for HCPCS/CPT codes 99283-99285

Updated %'s posted to PR050 on 3/2/2005, and should be present in your next extract. Design documents will be updated.

02 Out of State Hospitals use of Outpatient Hospital Fee Schedule

The Outpatient Fee Schedule Process will apply to both in and out of state Hospitals.

Design documents will be updated.

03 New Encounter Edits

Need to add new Encounter edits at the detail line level for UB's for line level begin and end dates of service. Includes – Valid dates; Begin date is before or same as end data; Line level begin and end dates are within header begin and end dates; Revenue codes and HCPCS to modifiers are valid on the line level dates of service; HCPCS coverage code is valid for the line level dates of service.

Design documents will be updated.

04 "Lesser of" rule for Outpatient Hospital Fee Schedule Reimbursed claims.

Claims reimbursed under the Outpatient Hospital Fee Schedule are not subject to lesser or allowed vs. billed charges. These claims will paid the allowed rate for the service regardless of the billed charges for the service.

05 Need to recognize and support "Bundled" service exceptions for the Surgery Bundle.

Per a recent update from Medicare certain HCPCS/CPT procedure codes, regardless of the revenue code to which they are associated on the claim, should bypass bundling.

For Example:

A claim has a Surgery HCPCS on line 3,
It also has three other lines with revenue codes 270 HCPCS L0100, 760 HCPCS 36415 and another 270 with a HCPCS of 59025,
Revenue code 270 would normally be bundled on Surgery claims,
However HCPCS code 59025 is an exception from Bundling,
So only the 270 line with HCPCS L0100 would be bundled,
And the 270 line with HCPCS code 59025 would be allowed according to the Fee Schedule.

This will necessitate the addition of a new Reference table for Exception HCPCS/CPT codes, new values for the Action Codes table and new bypass conditions in the claims/encounters O/P valuation programs. Values related to this processing can be found on reference table RF739 and in your REF03 extract.

06 Modify the AHCCCS Fee for Service Remittance Advice to include sufficient Outpatient line level processing detail as requested by the Hospitals.

Customer Change Requests – Not Yet Approved:

None.

OUTPATIENT HOSPTIAL FEE SCHEDULE PROJECT
SUMMARY OF UPDATES/ITEMS OF NOTE
2/2/2005 – 6/6/2005

- Updated percentages were received and are now posted for some Peer Groups (refer to attachment). Included in this is update is a new % of 210% for Phoenix Children's Hospital. There is also a new Peer Group of University Affiliated Hospitals. – These values have since been revised and finalized per the Final Rule, please refer to bullet point below for detailed information.

- While preparing Control Group claims, it was noted that a UB Bill Type range was missing from the definition of Bill Types to which the Outpatient Hospital Reimbursement applies. The applicable Bill Types as previously stated should also include all 7XX Clinic Bill Types.

- Several Health Plans noted that the Reference and Provider Extracts produced from the AHCCCS Test Environment were not inclusive of all tables previously discussed. This issue has been resolved, and, with the exception of RF618, the next extract should be all-inclusive.

- RF618 is not presently included in either the current or proposed Health Plan Reference extract. This is an issue that involves many factors and is currently under evaluation by the Encounter Unit. There is at this time a single value needed from this table to support Outpatient Hospital Reimbursement. The default CCR for O/P. The value for this is .2957 effective 7/1/2005. – This value has been revised and finalized per the Final Rule; the default CCR value for O/P is .3192.

- There have been several inquiries to the Workgroup as to when table values will be finalized. Table values will continue to be revised as necessary, however Table structures have been finalized and values loaded are to the best of our understanding current. – All tables are now in production and production values are being loaded and q.c'd. A full Production Reference extract will be available as soon as possible on the FTP server.

- There have also been several inquires to the Workgroup as to the following

  When does the new Fee Schedule Apply? – *Dates of Service on or after 7/1/2005.*

  What if my claim dates of service overlap 7/1/2005? – *AHCCCS will no longer allow O/P claims dates of service to overlap 7/1/2005.*

  Does the new Fee Schedule Processing Apply to Claims and Encounters? - *Yes*

  What if I get an O/P claim from a provider who is not a Hospital? - *The Outpatient Hospital Fee Schedule applies only to Provider Type 02 Hospitals.*

  Does the new Fee Schedule Apply to Late Charge Claims or Adjustments? - *No, Late Charge claims will no longer be allowed, and Adjustments were eliminated under HIPAA.*

- There have been several inquiries to the Workgroup as to the functionality of the RF773 and RF774 tables. RF774 indicates several things related to UB claims processing most importantly can you bill a particular Revenue Code on this type of Bill Type, and if so is a HCPCS/CPT (R)equired, (O)ptional or (N)ot Allowed. RF773 stores the HCPCS/CPT codes which are permissible for those Bill Type to Revenue Code relationships on RF774 which are (R) or (O).

- As noted by several Health Plans there are three new coverage codes appearing in your Reference extracts. The addition of two these codes was unrelated to the Outpatient Hospital Fee Schedule. The values are as follows:

  05 – Outpatient Hospital Service Will allow for coverage of service under the Outpatient Fee Schedule only and is covered in the AHCCCS Design Documentation

  09 – Medicare Only Will allow for the flagging of non-Medicaid covered services otherwise covered under Medicare

  10 – Non Pay Category 2 Codes Will allow for the flagging of Category 2 codes

- As previously discussed there was some confusion as to the handing of Same Day Admission –Discharge and Same Day Admission –Transfer Inpatient claims under the Outpatient Hospital Fee Schedule. This is a long standing Inpatient Hospital Reimbursement Policy as outlined in the current AHCCCS Fee for Service Provider Manual. Please refer to the attached for clarification.

- There have been a number of inquiries regarding Encounter Reporting requirements and new editing associated with the Outpatient Hospital Fee Schedule Project. The Encounter Unit is in the process of evaluating and communicating these requirements and changes. This will continue to be accomplished via Communication emails (there have been several in the last couple weeks), and updates to the Encounter Reporting Manual. – See latest communications attached.

- There have also been a number of inquiries to the Workgroup regarding the PR050 table and the Peer Group values. Facility Peer Groups are reflected in the form of rates on PR050 (P4) table. At this time the only valid Peer Group values are PGM and PG1. The % associated with these Peer Group values is to be used when calculating the final allowed amount for each Outpatient claim line paid with a rate from the Outpatient Fee Schedule. The % does not apply to claims allowed under the default cost to charge ratio. You should use the appropriate PGM or PG1 value for the line HCPCS code and the claim service date.

- There has been one adjustment to the Facility Peer Groups, University Physicians Hospital - Kino has been reassigned to the same Peer Group as University Medical Center. (refer to attached) – – These values have since been revised and finalized per the Final Rule, please refer to bullet point below for detailed information.

- Per the finalized Rules, there have been a number of adjustments to % values for Peer Groups which are reflected on the attached document. This document also reflects those "laboratory" code ranges to which the peer group adjusters do not apply.

- Final Surgery and E/R bundling qualifiers have been defined and are reflected in the tables as well as the attached document.